Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Northeast Division of Survey & Certification

July 8, 2014

Dr. Robert Simpson, President & CEO
Brattleboro Retreat
Anna Marsh Lane P.O. Box 803
Brattleboro, VT 05301

Re: CMS Certification Number: 474001
Survey ID: PLR911, 06/18/2014
Initial Notice of Termination

Dear Dr. Simpson:

Section 1865 of the Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations provide that a provider or supplier accredited by a CMS-approved Medicare accreditation program of The Joint Commission (TJC) will be "deemed" to meet all of the Medicare Conditions of Participation (CoPs) for hospitals. In accordance with Section 1864 of the Act, State Survey Agencies may conduct at CMS's direction, surveys of deemed status providers on a selective sampling basis, in response to a substantial allegation of noncompliance, or when CMS determines a full survey is required after a substantial allegation survey identifies substantial noncompliance. CMS uses such surveys as a means of validating the accrediting organization's survey and accreditation process.

A survey conducted by the Division of Licensing and Protection (State Survey Agency) at Brattleboro Retreat on June 18, 2014 found that the facility was not in substantial compliance with the following CoPs for hospitals:

42 CFR § 482.21 - Quality Assessment and Performance Improvement Program (QAPI)
42 CFR § 482.41 - Physical Environment

As a result, effective June 18, 2014, your deemed status has been removed and survey jurisdiction has been transferred to the State Survey Agency.

A listing of all deficiencies found is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction).

When a hospital, regardless of whether it has deemed status, is found to be out of compliance with the CoPs, a determination must be made that the facility no longer meets the requirements for participation as a provider or supplier of services in the Medicare program. Such a determination has been made in the case of Brattleboro Retreat and accordingly, the Medicare agreement between Brattleboro Retreat and CMS is being terminated. The date on which the Medicare agreement terminates is October 6, 2014.

The Medicare program will not make payment for services furnished to patients who are admitted on or after October 6, 2014. For inpatients admitted prior to October 6, 2014, payment may continue to be made for a maximum of 30 days of inpatient services furnished on or after October 6, 2014. You should submit as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your facility on October 6, 2014 to Kathy Mackin, DHHS/CMS, JFK Federal Building, Room 2325, Boston, MA, 02203 to facilitate payment for services to these individuals.

We will publish a public notice in the *Brattleboro Reformer* at least fifteen days prior to the termination date.

Termination can only be averted by correction of the deficiencies, through submission of an acceptable plan of correction (PoC) and subsequent verification of compliance by the State Survey Agency. The Form CMS-2567 with your PoC, dated and signed by your facility's authorized representative, must be submitted to the State Survey Agency no later than **July 18, 2014.** Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", keying your responses to the deficiencies on the left. Additionally, indicate your anticipated completion dates in the column labeled "Completion Date".

An acceptable PoC must contain the following elements:

1. The plan for correcting each specific deficiency cited;

2. The plan for improving the processes that led to the deficiency cited, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;

3. The procedure for implementing the PoC, if found acceptable, for each deficiency cited;

4. A completion date for correction of each deficiency cited;

5. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiencies cited remain corrected and in compliance with regulatory requirements; and

6. The title of the person(s) responsible for implementing the acceptable PoC.

Copies of the Form CMS-2567, including copies containing the facility's PoC, are

releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 C.F.R. § 401.133(a). As such, the PoC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

If an acceptable POC is timely submitted, your facility will be revisited to verify necessary corrections. If CMS determines that the reasons for termination remain, you will be so informed in writing, including the effective date of termination. If corrections have been made and your facility is in substantial compliance, the termination procedures will be halted, and you will be notified in writing.

If your Medicare agreement is terminated and you wish to be readmitted to the program, you must demonstrate to the State Survey Agency and CMS that you are able to maintain compliance. Readmission to the program will not be approved until CMS is reasonably assured that you are able to sustain compliance.

If your Medicare agreement is terminated and you do not believe this termination decision is correct, you may request a hearing before an Administrative Law Judge (ALJ) of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 C.F.R. Part 498. A written request for a hearing must be filed no later than 60 days from the date of receipt of the final notice of termination. Such a request, accompanied with a copy of the termination notice, may be made to:

Departmental Appeals Board, Civil Remedies Division
Room G-644-Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201
Attn: Director, Departmental Appeals Board

Please also forward a copy of any request for a hearing to:

J. William Roberson
Associate Regional Administrator
Northeast Division, Survey & Certification
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

A request for a hearing should identify the specific issues, the findings of fact and the conclusions of law, if applicable, with which you disagree. You may be represented by counsel at a hearing at your own expense.

Sincerely,

J. William Roberson
Associate Regional Administrator
Northeast Division, Survey & Certification

Enclosure: Form CMS-2567

cc: State Survey Agency
TJC

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OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474001	A. BUILDING _____ B. WING _____	C 06/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

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A 000	INITIAL COMMENTS An unannounced, on-site survey to investigate self-reported incident #11743, as authorized by the Centers for Medicare and Medicaid services, was conducted by staff from the Vermont Division of Licensing and Protection, from 6/16/14 to 6/18/14. The Conditions of Participation authorized for review included Patient Rights, QAPI, Nursing Services and Physical Environment. The following regulatory violations were found.	A 000		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation for Quality Assessment and Performance Improvement (QA/PI) was not met due to the hospital's failure to analyze and initiate action plans to ensure patient safety, based on a significant event report related to	A 263		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 263	Continued From page 1 access to patient rooms at all times. The information obtained during the investigation evidenced a systemic problem with a lack of communication of critical information between member(s) of the Safety Committee and the QAPI Committee and a failure to assure staff communication and referral of all patient safety concerns . Refer to A-286	A 263		
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established.	A 286		

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A 286	Continued From page 2 This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure that it's QAPI Program (Quality Assessment and Performance Improvement Program) analyzed and implemented preventive actions and mechanisms to provide feedback and learning strategies hospital wide related to patient adverse event reports. Findings include: Based on review of hospital events reports and interviews with members of the QAPI and Safety Committees on 6/17/14, the hospital failed to implement a plan to assure that staff had timely access to the Tyler 3 Unit patient rooms at all times, in the event of an emergency situation. Staff confirmed that patient rooms lock automatically when closed and that doors are kept closed when not occupied. Currently, patients are allowed to be in their rooms with the door locked for 5 minute periods to allow for privacy while dressing/undressing, with designated staff monitoring of the 5 minute time limit. When patient's wish to be in their rooms otherwise, the door is to be kept open several inches, to allow staff visual monitoring. Per review of event reports dating from January 30, 2014, to June 1, 2014, there were two instances when patients attempted suicide or self-harming behaviors behind locked bedroom doors, and a separate occasion when a key broke off in a patient bedroom door lock, necessitating a call to maintenance staff to remove the broken key from the lock to allow staff access to the patient room. During interview on 6/17/14 at 2:43 PM, the Director of Environmental Services	A 286		

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A 286	Continued From page 3 confirmed that a key had broken off in a patient locked door and that nursing staff called facilities personnel to remove the key to gain entrance to the room. He/she confirmed it would take about 5 minutes for staff to fix the lock, once on the unit after receiving the call. When asked if this had happened before, the Director of Maintenance stated that it was not a common occurrence but possibly one time per year. Later the same day (at 3:30 PM), during interview, the Director of Quality confirmed that there had been patient suicide attempts made in the patient rooms and that he/she was not aware of any instances where a key broke off in a Tyler 3 patient door lock. The Director Of Quality acknowledged that it would be a safety concern to gain timely access to a room in the event of a emergency situation. He/she estimated it could take as long as 20 minutes from event to access to the room in such an emergency. He/she confirmed that neither the Safety Committee nor the Quality Committee had analyzed and reviewed this event report and taken any action to ameliorate this potential risk for patient safety. The Director of the Environment confirmed (6/17/14) that he/she had not been involved in any hospital wide safety initiatives concerning this safety risk. Although the hospital put an interim safety plan in place (on 6/17/14 after the meeting with surveyors) so that staff on Tyler 3 and Osgood Units could gain timely access to patient rooms if needed, the failure to formulate a safety plan based on review of the original event report, posed a potential safety risk to the patients of the two units.	A 286		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE	A 395		

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A 395	Continued From page 4 A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing staff failed to provide ongoing evaluation and assessment of a patient with a change in health status, in accordance with accepted standards of nursing practice and hospital policy, for 1 of 10 patients in the targeted sample. (Patient #1) Findings include: Patient #1, who was hospitalized with Suicidal Ideation (SI)) and recent Self Harming (SH) behaviors, expressed a positive "Yes" response to safety screening questions during interview with a Mental Health Worker (MHW) #1 on 5/4/14 and the RN failed to complete a reassessment at that time, per facility policy. The following day, the patient attempted suicide in their room and required transfer to another hospital for medical treatment. Per record review on 6/16/14 and confirmed during interview with the MHW on 6/17/14 at 11:45 AM, the Patient Flow Sheet (a screening form used by MHW to note changes in patients), for Patient #1 dated 5/4/14 documented the following: "Verbalizing Suicidal Ideation: Yes, ...Isolating in Room: Yes,....Concerns/Interventions: Pt. rated her depression at an 8 out of 10 and endorsed SI and ....."feeling hopeless....". The Flow sheet stated the change in behavior/symptoms was reported to RN #1. During interview at the above stated time on 6/17/14, the MHW confirmed that she did report Patient #1's "Yes" answers obtained from the screening interview on 5/4/14 (Yes to SI and	A 395		

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A 395	Continued From page 5 Isolating in room), to her charge RN on 5/4/14, per the hospital's policy. Per review, the "Patient Safety Assessment and Documentation" policy (2013/08,) stated under "Shift Progress/Reassessment Note, #3, "Any 'yes' response(s) obtained from the patient during a safety screening interview, when done by a MHW or LPN (Licensed Practical Nurse), must be reported immediately to an RN. The RN will then complete a more comprehensive evaluation using the RN assessment of Patient Safety Progress Note." Per review of the medical record, there was no assessment completed by the day shift Charge RN, subsequent to "Yes" findings during the MHW's screening interview. During interview on 6/17/14 at 10 AM, RN #1 stated that he /she did not remember receiving any report from MHW #1 regarding changes in responses to the safety risk screening tool. The RN confirmed that if he/she had received such a report, a new assessment must be completed by the RN, per the hospital's policy. Reference: Per Vermont title 26: Professions and Occupations, Chapter 28, Nursing, "Registered Nursing " means the practice of nursing which includes: (A) Assessing the health status of individuals and groups; (H) Maintaining safe and effective nursing care rendered directly or indirectly; (I) Evaluating response to interventions; (L) Collaborating with other health professionals in the management of health care.	A 395		
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient,	A 700		

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A 700	Continued.From page 6 and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, staff interviews and record review, the hospital did not meet the Condition of Participation (COP) for Environment due to it's failure to assure that the environment was maintained to ensure the safety of the patients on 1 applicable unit of the hospital. The hospital failed to take action on an event report noting a potential patient safety concern related to a work order to fix a key broken in a patient's door lock on the Tyler 3 Unit. The hospital also failed to assure that the Tyler building elevator used by patients and staff during the 3 days of survey was maintained in a safe condition. Refer to A-701	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the hospital failed to ensure that the overall hospital environment was maintained in a manner that assured the safety of patients in all areas. Findings include: During the initial tour of the Tyler 3 Unit on 6/16/14, commencing at 11:30 AM and ending at 12:20 PM, a plastic ceiling light cover panel in the	A 701		

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A 701	Continued From page 7 elevator was observed to have multiple cracks and 2 holes, approximately 1.0 - 1.5 inches in diameter, posing a potential safety hazard related to possible patient self-harming behavior. Patients (accompanied by staff) use the elevator multiple times daily and could potentially pull down the panel and use it to injure themselves or another person. The broken ceiling cover in this elevator was observed by surveyors at various times on all three days of the survey. On the morning of 6/18/14, it was brought to the attention of the Director of Quality and the Director of Social Services during a meeting at 8:08 AM and subsequently repaired by hospital staff. During an interview on 6/16/14 at 1:15 PM with the Vice President of Operations and the Director of Maintenance, the Director of Maintenance stated that safety rounds are done quarterly. They do half of the units every quarter, so the entire facility is done every 6 months. He/she stated that it was a lengthy check list that was developed and that they are "not checking the 50 different boxes on every single unit". They rely on reports from MHW and housekeeping staff as well as the rounding done by facilities staff every day to find problems. He/she discussed on-going review of MHW rounds reports, review of incident reports and asking staff directly about any particular safety concerns, as methods used to identify areas requiring some type of work and/or repair. He/she confirmed that they do not have a formal process in place to monitor the work order process to assure that all areas in need are completed timely. Regarding the event report (and work order) of the broken key in a patient door on the Tyler 3 during the first quarter of 2014, the Director	A 701		

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A 701	Continued From page 8 confirmed this was a potential patient safety risk that he/she had not discussed at any monthly Safety Committee Meeting. It was noted that the same potential risk existed on the Osgood Unit, where the doors also lock automatically when closed. These safety risks were also reviewed with the Quality Committee during a meeting on 6/17/14 at 3:30 PM, where the Director of Quality reported that he/she was not previously aware of the existence of the event report regarding the broken key and therefore, it had not been previously reviewed by the entire committee. The hospital does have a plan to replace this type of door used on Tyler 3 and Osgood Units with a non-barricade door, per the Director of Maintenance.	A 701		

CMS
Centers for Medicare & Medicaid Services
Office of the Regional Administrator

Boston Region I
JFK Federal Building, Room 2325
Boston, MA 02203-0003
FAX #: 443-380-8871

Confidential Facsimile Transmittal

To: Dr. Robert Simpson, President & CEO
Company:
Fax: 8022583796
Phone

From: Kathy Mackin
Fax: 443-380-5597
Phone: (617) 565-1211
E-mail: kathy.mackin@cms.hhs.gov

Date and time: Tuesday, July 08, 2014 9:53:20 AM

Number of pages: 14

cc:

NOTES: Advanced copy of Notice of Findings